DOCUMENT RESUME

ED 480 052 CG 032 625

AUTHOR	Juhnke, Gerald A.; Hagedorn, William Bryce
TITLE	SUBSTANCE-Q: A Practical Clinical Interview for Detecting Alcohol and Other Drug Abuse.
PUB DATE	2003-08-00
NOTE	14p.; In: Measuring Up: Assessment Issues for Teachers, Counselors, and Administrators; see CG 032 608.
PUB TYPE	Information Analyses (070)
EDRS PRICE	EDRS Price MF01/PC01 Plus Postage.
DESCRIPTORS	*Alcohol Abuse; *Drug Abuse; *Evaluation Methods; *Measures (Individuals); *Student Evaluation
IDENTIFIERS	*Risk Factors

ABSTRACT

This chapter describes the SUBSTANCE-Q, and atheoretical assessment scale designed for use as a clinical interview with students who potentially abuse alcohol and other drugs (AOD). The scale is founded upon a clustering effect of 10 literature-identified risk factors that commonly occur among AOD abusing students. Each high risk factor is indicated in the chapter with a brief summary suggesting the reason for its inclusion. (Contains 26 references and 3 tables.) (GCP)

Reproductions supplied by EDRS are the best that can be made
from the original document

ED 480 052

SUBSTANCE-Q: A Practical Clinical Interview for Detecting Alcohol and Other Drug Abuse

By
Gerald A. Juhnke
William Bryce Hagedorn

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

- This document has been reproduced as received from the person or organization originating it.
- Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

BEST COPY AVAILABLE

CG032625

Chapter 17
SUBSTANCE-Q
A Practical Clinical Interview for Detecting Alcohol and Other Drug Abuse

Gerald A. Juhnke & William Bryce Hagedorn

This chapter describes the SUBSTANCE-Q, an atheoretical assessment scale designed for use as a clinical interview with students who potentially abuse alcohol and other drugs (AODs; Juhnke & Scholl, 1997). The scale is founded upon a clustering effect of 10 literature-identified risk factors that commonly occur among AOD abusing students. When these risk factors are assessed in sequence, the first letter of each risk factor corresponds with the acronym SUBSTANCE-Q. Thus, the acronym serves as a reminder of each of the 10 risk factors that warrant assessment. Following the established "S" through "Q" sequence ensures a thorough student substance abuse assessment. Each high-risk factor is indicated below with a brief summary suggesting the reason for its inclusion.

The 10 SUBSTANCE-Q Risk Factors

Substance Abusing Family Member. Students whose parents and siblings are AOD abusing are at greater risk for abusing AODs themselves (Biederman, Faraone, Monuteaux, & Feighner, 2000; Duncan, Duncan, & Hops, 1996). This seems especially true when AOD abusing parents and older siblings are respected and revered, and when these AOD abusing family members are noted as being important role models (Adlaf & Giesbrecht, 1996). Furthermore, when students are living with AOD abusing family members, psychoactive substances are often readily available within the home, and parents appear to be less concerned about students using AODs or becoming addicted. This may occur because AOD abusing family members don't perceive they have experienced significant negative consequences related to their AOD abuse and don't perceive themselves as being addicted (Kandel, Griesler, Lee, Davies, & Schaffran, 2001).

Undersocialization. This factor refers to students who report few significant friends or limited interactions with significant others. Often these students will present with poor interpersonal skills or reported alienation feelings (Sandhu, 2000). It is unknown whether their AOD abusing behaviors have stunted their social development or interpersonal skills, whether these students initially had limited desire to interact socially, or whether a combination of these factors influences their undersocialization (Brook & Whiteman, 1997). No matter the genesis, undersocialized students are at increased risk for AOD abuse and should be evaluated and referred whenever undersocialization is noted as a symptom of presenting psychopathology (e.g., undersocialization resulting from depression) or promoting AOD abuse (e.g., self-medicating due to undersocialization).

Behavioral Problems. There is a high correlation between deviant and AOD abusing behaviors (Dawkins, 1997; SAMHSA, 2001, Oct. 12). For example, some students may have been formally charged with criminal behaviors such as prostitution, driving while under the influence (DUI), selling AODs, or shoplifting (SAMHSA, 2001, Dec. 14). Still others may present as highly impulsive and sensation seeking (Palmgreen, Donohew, Lorch, Hoyle, & Stephenson, 2001).

Stressful Life Events. AOD abuse is also correlated with reported stressful life events (Biederman et al., 2000). Specifically, many AOD abusing students report using psychoactive substances to reduce anxiety related to stressful life events (Hoffman & Su, 1997). Some of these students may be predisposed to anxiety and, therefore, experience stressful events more acutely than do nonabusing students. It is also possible, however, that AOD abuse brings about stressful life events as well (Weinrich & Hardin, 1997). For example, AOD abusing students may experience stressful life events resulting from behaviors while under the influence, or their stressful life events may be related to dysfunctional interpersonal relationship dynamics that are exacerbated by AOD abusing behaviors.

Tobacco Use. There is a correlation between tobacco use and AOD abuse (Golub, Labouvie, & Johnson, 2000). A sizeable percentage of students who present with AOD abuse concerns also use tobacco. Thus, students using tobacco should be assessed for potential AOD abuse.

Academic Problems. Although there is a misperception by some that

all AOD abusing students experience academic problems, this is simply not true. Many AOD abusing students are intelligent and do well scholastically. There are indicators, however, suggesting that a significant percentage of AOD abusing students do experience academic difficulty (Dozier & Barnes, 1997; Register, Williams, & Grimes, 2001). Academic problems may result from significant absenteeism or interpersonal difficulties with peers and authority figures such as teachers. Those experiencing academic difficulties may turn to AODs to reduce the stresses of failure.

Negative Affect. For this scale, negative affect consists of two or more of the following: (a) lethargy, (b) lack of ambition, (c) pessimism, (d) low self-esteem, or (e) a low need for achievement. When combined with other risk factors, negative affect may signal increased probability for AOD use (Hofler & Lieb, 1999; Sutherland & Shepherd, 2001). Any student presenting negative affect, however, warrants immediate assessment to rule out potentially life-threatening behaviors.

Cohort Substance Abuse. Data suggest an increased probability that students will abuse AODs when their close friends and peers are abusing the same substances (NCADI, 2001; Olds & Thombs, 2001). Whenever students note that their close friends and peers are AOD abusing, further inquiry is warranted.

Endorsement of Substance Abuse. This risk factor is especially noteworthy. Students who indicate that they are AOD abusing automatically warrant treatment. Often students initially coming into treatment or being mandated into treatment will indicate they abuse AODs (AAP, 2001). Their statements should be believed, and appropriate treatment intervention should be established.

Quit in Past or Attempted to Quit. This risk factor is related to students who indicate that they have quit or attempted to quit abusing AODs. Often these students will indicate many attempts to discontinue AOD abuse altogether or will indicate they have attempted to decrease their AOD abuse (Stanton & McClelland, 1996).

Once the SUBSTANCE-Q risk factors have been assessed, a score can then be determined. The following intervention strategies, which correspond to each student's score, will aid in the treatment of the affected student.

Scoring and Intervention Guidelines

For each of the SUBSTANCE-Q risk factors, students receive a score between 0 (complete absence of the risk factor) and 10 (significant manifestation of the risk factor). Proposed intervention guidelines are based upon behavioral scoring anchors (Table 1) and total number of points received (Table 2). This total number can range between 0 and 100. The purpose of this clinical interview scale is to ensure a thorough addiction assessment and to augment counselors' clinical judgment when they perceive that students may be AOD abusing. Therefore, the instrument is used only when students are perceived as possibly having an AOD abuse–related concern. Besides the relation to AOD abuse risk factors, the scale's numerical score is correlated to general clinical guidelines that suggest minimal intervention standards. These general guidelines should be adjusted according to the student's specific needs and voiced concerns.

Low SUBSTANCE-Q Scores

The responses of students perceived as AOD abusing who score between 0 and 15 may very well be suspect. Such low scores may indicate students are attempting to present themselves in a favorable manner and are not admitting their AOD abuse concerns or related experiences. Such low scores suggest students are denying the presence of AOD abusing behaviors and experiences commonly acknowledged by AOD addicted students. The primary issue with such low scores is the incongruence between the counselor's initial perceptions related to the student's suspected AOD abuse and the student's low score. Consulting with one's clinical supervisor and professional peers can help clarify whether the counselor's original concerns were likely

TABLE 1. The SUBSTANCE-Q Clinical Interview

Substance Abusing Family Members/Significant Others
Under socialized
Behavioral Problems
Stressful Life Events
Tobacco Use
Academic Problems
Negative Affect
Cohort Substance Abuse
Endorses Substance Abuse
Quit In the Past or Previously Attempted Quits

TABLE 2. SUBSTANCE-Q Clinical Interview Behavioral Scoring Anchors

Substance Abusing Family Member/Significant Others

0	No Substance Abusing Family Members
5	At least one respected family member abusing substances on a regular basis
10	At least one respected family member abusing substances who has had substance-related negative effects (e.g., job termination, DUI charges, etc.) resulting from frequent and regular substance abuse

Under socialized

0	Good social skills and significant support from others
5	Limited social skills or limited support
10	Poor social skills or very limited support

Behavioral Problems

0	No deviant, criminal, or antisocial behaviors noted
5	Unconventional attitudes or minor rebellion toward authority figures or minor law infractions
10	Recent or recurrent criminal behaviors or high sensation seeking or animosity toward authority figures.

Stressful Life Events

0	Stressful life events denied and student appears to be experiencing a life free from major stressors
5	Some noteworthy stressful life events are noted. These stressors are reported at times as being difficult but are neither insurmountable or thoroughly overwhelming
10	Noteworthy stressful life events are noted and the student reports that the stressors are often perceived as overwhelming

Tobacco Use

0	Student denies smoking tobacco
5	Student reports occasionally smoking tobacco cigarettes or cigars, but reports smoking less than one pack of tobacco cigarettes each week and less than three tobacco cigars per week.
10	Student reports smoking at least one pack of tobacco cigarettes or one tobacco cigar per day

Academic Problems

0	No academic problems noted
5	Decline in academic relations or performance or attendance resulting from substance abuse or substance-related behaviors, or in jeopardy of being dismissed, suspended, or failed due tsubstance abuse or substance-related behaviors
10	Academic course failure resulting from substance abuse or substance-related behaviors or performance or attendance problems resulting from substance abuse or substance-related behaviors

Negative Affect

0	No lethargy or lack of ambition or pessimism or low self-esteem or low need for achievement noted.
5	Moderate amounts of any of the aforementioned noted
10	Significant amounts of any of the aforementioned noted

Cohort Substance Abuse

0	No close friends or peers are reported as abusing AODs
5	Infrequent AOD abuse by close friend(s)
10	Frequent AOD abuse by close friend(s)

Endorses Substance Abuse

0	Student denies AOD abuse
5	Student reports infrequent AOD abuse
10	Student reports frequent AOD abuse

Quit In the Past or Previously Attempted Quits

0	No previous attempts or thoughts of discontinuing alcohol use
5	No previous attempts or thoughts of discontinuing drug use other than alcohol which costs less than $10 per week, or one or fewer attempts to discontinue AOD use
10	Does not perceive a need to discontinue drug use of more than $10 per week, or more than one attempt to discontinue AOD use.

TABLE 3. SUBSTANCE-Q Clinical Interview Scores with General Clinical Guidelines

Scores	General Clinical Guidelines
0 to 15	Consult clinical supervisor to clarify whether initial AOD concerns regarding the student were likely unfounded. If concerns were unfounded and no basis for questioning the veracity of the student's responses exist, disseminate information indicating how student can access counselors if needed in the future and provide a single follow-up telephone call in 10 to 14 days to reassess possible needs. Oppositely, should the student's responses be suspect, additional assessment via significant other clinical interviews and AOD speciality assessments (e.g., the Substance Abuse Subtle Screening Inventory-Adolescent) are warranted.
16 to 39	If responses do not appear suspect, participation in counseling should be encouraged to address AOD abuse or other voiced concerns. If responses appear suspect, additional assessment via significant other clinical interviews and AOD specialty assessments is warranted.
40 to 59	Counseling and 12-step participation should be advocated. The local 24-hour helpline and relevant support group (e.g., Al-Ateen) telephone numbers should be provided. Student must agree to a "no suicide" and a "no harm" contract. Additional assessment is necessary to determine types, frequency, and amounts of AODs used – especially AODs used within the current year. Rule out the need for detoxification.

60 to 100 Counseling and 12-step participation are required. In addition to providing local helpline and 12-step support group numbers, and requiring the student to agree to a no suicide and no harm contract, detoxification and a restricted environment must be ruled out. Additionally, further assessment is required. Specifically such assessment should note types of AODs used, as well as the frequency of use and amounts typically taken.

If the counselor's original concerns seem unfounded, he or she should inform students about how to access counseling services in the future should the students need help. A single follow-up telephone call within the next 10 to 14 days to reassess the situation and remind students of available services is also suggested. On the other hand, should a student's responses appear suspect, additional assessment is clearly warranted, and depending on the outcome of these assessments, relevant intervention should be conducted to ensure clinically appropriate treatment.

The presence of certain risk factors, even by themselves, warrant further assessment and intervention. For example, it is logical that students who endorse AOD abuse should receive addiction treatment recommendations. Those who report stressful life events, academic problems, or negative affect should be referred for counseling.

Low to Moderate SUBSTANCE-Q Score

Scores between 16 and 39 suggest substance abuse. Additional assessment is warranted if responses appear suspect or if counselors are uncertain whether DSM-IV-TR abuse or dependence criteria are fulfilled. Recommendations for follow-up counseling are a means to address presenting AOD abuse symptoms or other voiced concerns. Follow-up visits are indicated to monitor the students' immediate conditions and to ensure that appropriate services are made available should a change in their conditions warrant more intensive interventions. Giving students a business card with both the local 24-hour crisis and local support group telephone numbers printed on the front and 35 cents taped to the back can provide students with the means to obtain help should they need it.

Moderate to High SUBSTANCE-Q Scores

Those scoring between 40 and 59 points are experiencing a moderate to high number of AOD abuse risk factors and likely warrant addiction treatment. Further assessment related to the types of AODs

used, onset of AOD use, frequency of use, and money typically spent each week on AOD abusing behaviors will be helpful. These students should be encouraged to investigate and participate in a relevant 12-step support group (e.g., Alateen). Given the frequency of suicide and violence among AOD abusing students (Dawkins, 1997; Tanskanen, 2000), students scoring in this range should sign a no suicide and no harm contract. This contract has students promise counselors and significant others (e.g., friends, family members, etc.) that they will call the 24-hour crisis hotline should they feel overwhelmed, depressed, or like hurting themselves or others.

Certainly, such contracts hold no legal recourse, and they can't inhibit students from dangerous behaviors (Barnett, 1994). They do, however, provide counselors with robust information and delineate a plan that students and their families and friends can follow. For example, should a student refuse to enter into a no suicide contract, it is clinically appropriate to assess the student for immediate danger and to hospitalize him or her if necessary. In other words, if any students refuse to agree to a no suicide contract, it suggests that those students are entertaining suicidal ideation and may have a plan to harm themselves. Thus, further assessment is warranted and protective measures must be enacted to protect these students from self-harm.

High SUBSTANCE-Q Scores

Scores of 60 or greater suggest significant AOD abuse, as well as possible environmental and emotional stressors. These students are at significant risk for substance abuse or dependence and likely warrant direct intervention. Depending on the amount and frequency of noted AOD abuse, students whose scores fall at the extreme end of this AOD risk continuum warrant possible referral for detoxification. Participation in a 12-step support group should be required, concomitant with addiction counseling. As indicated for moderate to high responses, the student should sign a no suicide and no harm contract and be provided a 24-hour crisis hotline number.

Clearly counselors should recognize that the presence of any single 10-point factor does not mean students are substance abusing or dependent. As noted, however, a clustering of high-risk factors, as noted above, suggests increased risk of substance abuse or dependence. Again, high scores on single factors such as academic problems, behavioral problems, or stressful life events may not by themselves indicate substance abuse or dependence, but they may suggest the need for general counseling services.

Conclusion

School counselors have multiple responsibilities to the students and families they serve, and students and families desire prompt and effective counseling services. The ability to assess student AOD abuse immediately without having to refer can be a significant asset to counselors and students alike. The SUBSTANCE-Q can be easily implemented with students during typical face-to-face clinical assessments and provides school counselors the opportunity to learn about potential student concerns and problems without requiring standardized written testing instruments. As this chapter has noted, in administering and scoring the SUBSTANCE-Q, obtained scores link directly to practical counseling recommendations and guidelines.

Based upon our experiences, we believe the SUBSTANCE-Q allows school counselors an opportunity to quickly establish the basic rapport necessary in assessing the AOD treatment needs of students. Additionally, the student interview enables counselors immediately to assess and implement standardized counseling recommendations that encourage student follow-up and continuity of care. Finally, the use of the SUBSTANCE-Q clinical interview ensures that the counselor asks fundamental questions regarding student AOD abuse and concerns. Therefore, school counselors can intervene before a student engages in more potentially dangerous and lethal AOD abuse behaviors.

References

AAP [American Academy of Pediatrics]. (2001). Improving substance abuse prevention, assessment, and treatment financing for children and adolescents. *Pediatrics, 108*(4), 1025–1030.

Adlaf, E., & Giesbrecht, N. (1996). The substance use–delinquency nexus. *Addiction, 91*(4), 504–507.

Barnett, C. (1994). Symbolic safeguard. *Nursing, 24*(10), 72.

Biederman, J., Faraone, S. V., Monuteaux, M. C., & Feighner, J. A. (2000). Patterns of alcohol and drug use in adolescents can be predicted by parental substance use disorders. *Pediatrics, 106*(4), 792–798.

Brook, J. S., & Whiteman, M. (1997). Drug use and delinquency: Shared and unshared risk factors in African American and Puerto Rican adolescents. *Journal of Genetic Psychology, 158*(1), 25–40.

Dawkins, M. P. (1997). Drug use and violent crime among adolescents. *Adolescence, 32*(126), 395–406.

Dozier, A. L., & Barnes, M. J. (1997). Ethnicity, drug user status and academic performance. *Adolescence, 32*(128), 825–838.

Duncan, T. E., Duncan, S. C., & Hops, H. (1996). The role of parents and older siblings in predicting adolescent substance use: Modeling development via structural equation latent growth methodology. *Journal of Family Psychology, 10*(2), 158–172.

Golub, A., Labouvie, E., & Johnson, B. D. (2000). Response reliability and the study of adolescent substance use progression. *Journal of Drug Issues, 30*(1), 103–119.

Hoffman, J. P., & Su, S. S. (1997). The conditional effects of stress on delinquency and drug use: A strain theory assessment of sex differences. *Journal of Research in Crime & Delinquency, 34*(1), 46–79.

Hofler, M., & Lieb, R. (1999). Covariates of cannabis use progression in a representative population sample of adolescents: A prospective examination of vulnerability and risk factors. *Addiction, 94*(11), 1679–1695.

Juhnke, G. A., & Scholl, M. B. (1997, April 5). *SUBSTANCE-Q: A substance abuse assessment scale.* Presented at the 1997 American Counseling Association World Conference, Orlando, FL.

Kandel, D. B., Griesler, P. C., Lee, G., Davies, M., & Schaffran, C. (2001). *Parental influences on adolescent marijuana use and the baby boom generation: Findings from the 1979–1996 National Household Surveys on Drug Abuse.* Substance Abuse and Mental Health Services Administration, Office of Applied Studies, Analytic Series: A-13, DHHS Publication No. (SMA) 01–3531, Rockville, MD: U.S. Department of Health and Human Services.

Miller, F. G., & Lazowski, L. E. (2001). *The adolescent SASSI-A2 manual: Identifying substance user disorders.* Springville, IN: SASSI Institute.

NCADI [National Clearinghouse for Alcohol and Drug Information]. (2001, Nov. 2). *Youth tobacco surveillance: United States, 2000.* CDC/MMWR Surveillance Summaries. Retrieved February 3, 2003 from www.cdc.gov/mmwr/preview/mmwrhtml/ss5004a1.htm.

Olds, R. S., & Thombs, D. L. (2001). The relationship of adolescent perceptions of peer norms and parent involvement to cigarette and alcohol use. *Journal of School Health, 71*(6), 223–229.

Palmgreen, P., Donohew, L., Lorch, E. P., Hoyle, R. H., & Stephenson, M. T. (2001). Television campaigns and adolescent marijuana use: Tests of sensation seeking targeting. *American Journal of Public Health, 91*(2), 292–297.

Register, C. A., Williams, D. R., & Grimes, P. W. (2001). Adolescent drug use and educational attainment. *Education Economics, 9*(1), 1–18.

SAMHSA [Substance Abuse and Mental Health Services Administration]. (2001, Oct. 12). Youth violence linked to substance use. *The NHSDA Report.* Retrieved from www.samhsa.gov/oas/facts/Violence.htm

SAMHSA [Substance Abuse and Mental Health Services Administration]. (2001, Dec. 14). Alcohol use.

The NHSDA Report. Retrieved from www.samhsa.gov/oas/2k2/alcNS/alcNS.htm.

Sandhu, D. S. (2000). Alienated students: Counseling strategies to curb school violence. *Professional School Counseling, 4*(2), 81–86.

Stanton, W. R., & McClelland, M. (1996). Prevalence, reliability and bias of adolescents' reports of smoking and quitting. *Addiction, 91*(11), 1705–1715.

Sutherland, I., & Shepherd, J. P. (2001). Social dimensions of adolescent substance use. *Addiction, 96*(3), 445–459.

Tanskanen, A. (2000). Joint heavy use of alcohol, cigarettes and coffee and the risk of suicide. *Addiction, 95*(11), 1699–1705.

Weinrich, S., & Hardin, S. (1997). Social support and psychological correlates of high school students who use illicit drugs in response to stress. *American Journal of Health Studies, 13*(1), 17–27.

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
National Library of Education (NLE)
Educational Resources Information Center (ERIC)

NOTICE

Reproduction Basis

	This document is covered by a signed "Reproduction Release (Blanket)" form (on file within the ERIC system), encompassing all or classes of documents from its source organization and, therefore, does not require a "Specific Document" Release form.
X	This document is Federally-funded, or carries its own permission to reproduce, or is otherwise in the public domain and, therefore, may be reproduced by ERIC without a signed Reproduction Release form (either "Specific Document" or "Blanket").